House of Representatives

General Assembly

File No. 191

February Session, 2004

House Bill No. 5467

House of Representatives, March 23, 2004

The Committee on Insurance and Real Estate reported through REP. OREFICE of the 37th Dist., Chairperson of the Committee on the part of the House, that the bill ought to pass.

AN ACT CONCERNING DISCLOSURE OF PARTICIPATING AND NONPARTICIPATING PROVIDER REIMBURSEMENT UNDER MANAGED CARE PLANS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-478g of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2004*):

(a) Each managed care contract delivered, issued for delivery, renewed, amended or continued in this state on or after October 1, 1997, shall be in writing and a copy thereof furnished to the group contract holder or individual contract holder, as appropriate. Each such contract shall contain the following provisions: (1) Name and address of the managed care organization; (2) eligibility requirements; (3) a statement of copayments, deductibles or other out-of-pocket expenses the enrollee must pay; (4) a statement of the nature of the health care services, benefits or coverages to be furnished and the period during which they will be furnished and, if there are any

services, benefits or coverages to be excepted, a detailed statement of such exceptions; (5) a statement of terms and conditions upon which the contract may be cancelled or otherwise terminated at the option of either party; (6) claims procedures; (7) enrollee grievance procedures; (8) continuation of coverage; (9) conversion; (10) extension of benefits, if any; (11) subrogation, if any; (12) description of the service area, and out-of-area benefits and services, if any; (13) a statement of the amount the enrollee or others on his behalf must pay to the managed care organization and the manner in which such amount is payable; (14) a statement that the contract includes the endorsement thereon and attached papers, if any, and contains the entire contract; (15) a statement that no statement by the enrollee in his application for a contract shall void the contract or be used in any legal proceeding thereunder, unless such application or an exact copy thereof is included in or attached to such contract; and (16) a statement of the grace period for making any payment due under the contract, which shall not be less than ten days. The commissioner may waive the requirements of this subsection for any managed care organization subject to the provisions of section 38a-182.

(b) Each managed care organization shall provide **[**every**]** each enrollee with a plan description. The plan description shall be in plain language as commonly used by the enrollees and consistent with chapter 699a. The plan description shall also be made available to each enrollee and potential enrollee prior to the enrollee's entering into the contract and during any open enrollment period. The plan description shall not contain provisions or statements that are inconsistent with the plan's medical protocols. The plan description shall contain:

(1) A clear summary of the provisions set forth in subdivisions (1) to (12), inclusive, of subsection (a) of this section, subdivision (3) of subsection (a) of section 38a-478c, as amended, and sections 38a-478j to 38a-478l, inclusive;

(2) A statement of the number of managed care organization's utilization review determinations not to certify an admission, service,

procedure or extension of stay, and the denials upheld and reversed on appeal within the managed care organization's utilization review procedure;

(3) A description of emergency services, the appropriate use of emergency services, including to the use of E 9-1-1 telephone systems, any cost sharing applicable to emergency services and the location of emergency departments and other settings in which participating physicians and hospitals provide emergency services and post stabilization care;

(4) Coverage of the plans, including exclusions of specific conditions, ailments or disorders;

(5) The use of drug formularies or any limits on the availability of prescription drugs and the procedure for obtaining information on the availability of specific drugs covered;

(6) The number, types and specialties and geographic distribution of direct health care providers;

(7) Participating and nonparticipating provider reimbursement [procedure] procedures, including, but not limited to, the information and procedures used in calculating and adjusting provider reimbursement;

(8) Preauthorization and utilization review requirements and procedures, internal grievance procedures and internal and external complaint procedures;

(9) The medical loss ratio, or percentage of total premium revenue spent on medical care compared to administrative costs and plan marketing;

(10) The plan's for-profit, nonprofit incorporation and ownership status;

(11) Telephone numbers for obtaining further information,

including the procedure for enrollees to contact the organization concerning coverage and benefits, claims grievance and complaint procedures after normal business hours;

(12) How notification is provided to an enrollee when the plan is no longer contracting with an enrollee's primary care provider;

(13) The procedures for obtaining referrals to specialists or for consulting a physician other than the primary care physician;

(14) The status of the National Committee for Quality Assurance (NCQA) accreditation;

(15) Enrollee satisfaction information; and

(16) Procedures for protecting the confidentially of medical records and other patient information.

This act shall take effect as follows:	
Section 1	*October 1, 2004*

INS *Joint Favorable*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 05 $	FY 06 $
Office of Managed Care Ombudsman	IF - None	None	None

Note: IF=Insurance Fund

Municipal Impact: None

Explanation

The bill increases the amount of information a managed care organization is required to provide on a plan description. The bill has no fiscal impact on the Office of Managed Care Ombudsman.

OLR Bill Analysis
HB 5467

AN ACT CONCERNING DISCLOSURE OF PARTICIPATING AND NONPARTICIPATING PROVIDER REIMBURSEMENT UNDER MANAGED CARE PLANS

SUMMARY:
Current law requires managed care organizations (MCO) to provide plan enrollees with a plain language plan description. This bill expands the plan description with respect to provider reimbursement procedures. It requires that the description include information and procedures used to calculate and adjust participating and nonparticipating provider reimbursements.

EFFECTIVE DATE: October 1, 2004

MANAGED CARE PLAN DESCRIPTION

By law, the MCO must provide each enrollee with a plan description, which must also be available to prospective enrollees and during open enrollment periods. The description must include a clear summary of:

1. certain information from the managed care contract,
2. the MCO's financial arrangements with providers and utilization review (UR) companies,
3. coinsurance based on negotiated discounts,
4. the gag clause prohibition, and
5. the consumer report card requirement.

The description must also include:
1. the number of adverse UR determinations, and denials upheld and reversed on appeal;
2. emergency services information;
3. plan coverage, including specific exclusions;
4. the use of drug formularies or any prescription drug availability limits, and procedures for obtaining information on the availability of specific drugs covered;
5. number, type, specialties, and geographic distribution of providers;

6. provider reimbursement procedures;
7. preauthorization and UR requirements, internal grievance procedures, and external complaint process;
8. medical loss ratio;
9. the plan's ownership status;
10. telephone numbers for more information;
11. procedures for notifying an enrollee when the plan no longer contracts with his primary care provider;
12. specialist and consultant referral procedures;
13. National Council on Quality Assurance (NCQA) accreditation status;
14. enrollee satisfaction information; and
15. confidentiality procedures for medical records and patient information.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Report
Yea 17 Nay 1